House of Representatives

General Assembly

File No. 36

January Session, 2015

House Bill No. 5832

House of Representatives, March 10, 2015

The Committee on Insurance and Real Estate reported through REP. MEGNA of the 97th Dist., Chairperson of the Committee on the part of the House, that the bill ought to pass.

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR TOMOSYNTHESIS FOR BREAST CANCER SCREENINGS.

Be it enacted by the Senate and House of Representatives in General Assembly convened:

Section 1. Section 38a-503 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(a) (1) Each individual health insurance policy providing coverage of the type specified in subdivisions (1), (2), (4), (10), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for mammographic examinations to any woman covered under the policy that are at least equal to the following minimum requirements: (A) A baseline mammogram for any woman who is thirty-five to thirty-nine years of age, inclusive; and (B) a mammogram every year for any woman who is forty years of age or older.

(2) Such policy shall provide additional benefits for:

(A) Comprehensive ultrasound screening or tomosynthesis of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse; and

(B) Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

(b) Benefits under this section shall be subject to any policy provisions that apply to other services covered by such policy, except that no such policy shall impose a copayment that exceeds a maximum of twenty dollars for an ultrasound screening under subparagraph (A) of subdivision (2) of subsection (a) of this section.

(c) Each mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound screening, a breast tomosynthesis, or a breast MRI examination, **[**or both,**]** depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's office and you should contact your physician if you have any questions or concerns about this report.".

Sec. 2. Section 38a-530 of the general statutes is repealed and the following is substituted in lieu thereof (*Effective January 1, 2016*):

(a) (1) Each group health insurance policy providing coverage of the

type specified in subdivisions (1), (2), (4), (11) and (12) of section 38a-469 delivered, issued for delivery, renewed, amended or continued in this state shall provide benefits for mammographic examinations to any woman covered under the policy that are at least equal to the following minimum requirements: (A) A baseline mammogram for any woman who is thirty-five to thirty-nine years of age, inclusive; and (B) a mammogram every year for any woman who is forty years of age or older.

(2) Such policy shall provide additional benefits for:

(A) Comprehensive ultrasound screening or tomosynthesis of an entire breast or breasts if a mammogram demonstrates heterogeneous or dense breast tissue based on the Breast Imaging Reporting and Data System established by the American College of Radiology or if a woman is believed to be at increased risk for breast cancer due to family history or prior personal history of breast cancer, positive genetic testing or other indications as determined by a woman's physician or advanced practice registered nurse; and

(B) Magnetic resonance imaging of an entire breast or breasts in accordance with guidelines established by the American Cancer Society.

(b) Benefits under this section shall be subject to any policy provisions that apply to other services covered by such policy, except that no such policy shall impose a copayment that exceeds a maximum of twenty dollars for an ultrasound screening under subparagraph (A) of subdivision (2) of subsection (a) of this section.

(c) Each mammography report provided to a patient shall include information about breast density, based on the Breast Imaging Reporting and Data System established by the American College of Radiology. Where applicable, such report shall include the following notice: "If your mammogram demonstrates that you have dense breast tissue, which could hide small abnormalities, you might benefit from supplementary screening tests, which can include a breast ultrasound

screening, a breast tomosynthesis, or a breast MRI examination, **[**or both,**]** depending on your individual risk factors. A report of your mammography results, which contains information about your breast density, has been sent to your physician's office and you should contact your physician if you have any questions or concerns about this report.".

This act shall take effect as follows and shall amend the following sections:		
Section 1	*January 1, 2016*	38a-503
Sec. 2	*January 1, 2016*	38a-530

INS *Joint Favorable*

OFA Fiscal Note

State Impact:

Agency Affected	Fund-Effect	FY 16 $	FY 17 $
State Comptroller - Fringe Benefits (State Employees and Retiree Health Accounts)	GF, TF - Cost	Approximately $87,673 to $363,216	Approximately $175,346 to $726,433
The State	Indeterminate - Cost	Approximately $43,263 to $179,232	Approximately $86,526 to $358,464

GF & TF = General Fund and Special Transportation Fund

Municipal Impact:

Municipalities	Effect	FY 16 $	FY 17 $
Various Municipalities	STATE MANDATE - Cost	Approximately $53,330 to $220,938	Approximately $106,660 to $441,876

Explanation

The bill will result in a cost to the state employee and retiree health plan[1], municipalities, and the state, for providing coverage for tomosynthesis in the event (1) a mammogram shows dense breast tissue, or (2) the woman is believed to be at increased risk for breast cancer. Under current law, coverage for ultrasound screenings is already required under the same conditions. The total estimated cost to the state in FY 16 is between $130,936 to $542,448 and $261,872 to $1,084,897 in FY 17. This cost is attributable to (1) the estimated cost to the state plan in FY 16 of between $87,673 to $363,216 and $175,346 to $726,433 in FY 17 and (2) the cost to the state pursuant to the federal Affordable Care Act (ACA) (see below) in FY 16 of between $43,263 to

[1] The state employee and retiree health plan is a self-insured health plan. Pursuant to federal law, self-insured health plans are exempt from state health mandates. However, the state has traditionally adopted all state health mandates.

$179,232 and $86,526 to $358,464 FY 17. The cost to fully insured municipalities in FY 16 is between $53,330 to $220,938 and $106,660 to $441,876 in FY 17.[2]

The fiscal impact assumes ultrasound claims will be replaced with tomosynthesis claims to some extent. The fiscal impact may be mitigated based on actual utilization and the availability of tomosynthesis.

The state plan does not currently provide coverage for experimental/investigational treatments except in specific circumstances involving individuals with cancer. Tomosynthesis is currently considered experimental under the state employee and retiree health plan and not medically necessary. Secondly, the cost to the state pursuant to the ACA may be underrepresented as it is uncertain at this time if the enrollment information reported reflects the total number of covered lives by exchange plans or the number of individuals who purchased a policy. Lastly, the cost to the state plan and municipalities may be mitigated to the extent the plans are able to utilize administrative methods such as prior authorization to approve coverage for certain procedures.

Municipal Impact

As previously stated, the bill may increase costs to certain fully insured municipal plans that do not currently provide coverage for tomosynthesis. The coverage requirements may result in increased premium costs when municipalities enter into new health insurance contracts after January 1, 2016. In addition, many municipal health

[2] The estimated cost is based on the per member per month (PMPM) rate of $0.07 to $0.29, which assume 25% replacement of ultrasounds and 100% replacement respectively. The pmpm assumes a cost differential between ultrasounds and tomosynthesis. The cost estimate for the state employee plan is based on the plan membership as of January 2015; municipal impact is based on Dept. of Labor employment information as of December 31, 2014; state impact based on Exchange enrollment is as of February 2015. Exchange enrollment excludes Medicaid enrollees totaling 382,021.

plans are recognized as "grandfathered" health plans under the ACA.[3] It is unclear what effect the adoption of certain health mandates will have on the grandfathered status of certain municipal plans under ACA. Pursuant to federal law, self-insured health plans are exempt from state health mandates.

The State and the federal ACA

Lastly, the ACA requires that, the state's health exchange's qualified health plans (QHPs)[4], include a federally defined essential health benefits package (EHB). The federal government is allowing states to choose a benchmark plan[5] to serve as the EHB until 2016 when the federal government is anticipated to revisit the EHB.

While states are allowed to mandate benefits in excess of the EHB, the federal law requires the state to defray the cost of any such additional mandated benefits for all plans sold in the exchange, by reimbursing the carrier or the insured for the excess coverage. State mandated benefits enacted after December 31, 2011 cannot be considered part of the EHB for 2014-2015 unless they are already part of the benchmark plan.[6] However, neither the agency nor the mechanism for the state to pay these costs has been established.

The Out Years

The annualized ongoing fiscal impact identified above would continue into the future subject to (1) inflation, (2) the number of covered lives in the state, municipal and exchange health plans, and (3) the utilization of services.

Sources: *Department of Labor*
Office of the State Comptroller

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[3] Grandfathered plans include most group insurance plans and some individual health plans created or purchased on or before March 23, 2010.

[4] The state's health exchange, Access Health CT, opened its marketplace for Connecticut residents to purchase QHPs from carriers, with coverage starting January 1, 2014.

[5] The state's benchmark plan is the Connecticare HMO plan with supplemental coverage for pediatric dental and vision care as required by the ACA.

[6] *Source*: Dept. of Health and Human Services. *Frequently Asked Questions on Essential Health Benefits Bulletin* (February 21, 2012).

OLR Bill Analysis

HB 5832

AN ACT CONCERNING HEALTH INSURANCE COVERAGE FOR TOMOSYNTHESIS FOR BREAST CANCER SCREENINGS.

SUMMARY:

This bill requires certain health insurance policies to cover tomosynthesis or ultrasound screening, instead of just ultrasound screening, when a (1) mammogram shows dense breast tissue or (2) woman is at increased risk for breast cancer. Tomosynthesis is a type of mammography that creates a three-dimensional picture of a breast using X-rays.

The law requires mammography reports sent to patients to include a notice about dense breast tissue. The bill requires such notices to indicate that breast tomosynthesis is a possible supplemental screening test if a mammogram reveals the patient has dense breast tissue.

The bill's coverage requirement applies to individual and group policies delivered, issued, renewed, amended, or continued in Connecticut that cover (1) basic hospital expenses; (2) basic medical-surgical expenses; (3) major medical expenses; or (4) hospital or medical services, including coverage under an HMO plan. It also applies to individual policies that cover limited benefits. Due to the federal Employee Retirement Income Security Act (ERISA), state insurance benefit mandates do not apply to self-insured benefit plans.

EFFECTIVE DATE: January 1, 2016

BACKGROUND

Related Federal Law

Under the federal Patient Protection and Affordable Care Act (P.L. 111-148), a state may require health plans sold through the state's

health insurance exchange to offer benefits beyond those included in the required "essential health benefits," provided the state defrays the cost of those additional benefits. The requirement applies to benefit mandates a state enacts after December 31, 2011. Thus, the state must pay the insurance carrier or enrollee to defray the cost of any new benefits mandated after that date.

COMMITTEE ACTION

Insurance and Real Estate Committee

Joint Favorable
Yea 16 Nay 1 (02/25/2015)